Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP PA
517 N CARRIER PARKWAY SUITE G
GRAND PRAIRIE TX 75050

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-11-2255-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Pre-authorized - #00005A4F7430…3rd FCE billed/have not exceeded limit."

Amount in Dispute: $2,938.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation submitted with the Request for Medical Fee Dispute Resolution, as well as subsequent documentation received in the claim file. Based on that review, the Carrier has determined the Provider is entitled to reimbursement for the disputed FCE (DOS 04-02-2010). Reimbursement for the FCE is being issued in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation. The remaining dates of service were previously reimbursed on reconsideration, and as such, the Provider is not entitled to additional reimbursement. With the supplemental reimbursement now issued, the Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers, 1501 S. Mopac Expressway, Suite A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2010	97799-CP x 8 hours	$800.00	$0.00
March 12, 2010	97799-CP x 8 hours	$800.00	$0.00
March 19, 2010	97799-CP x 8 hours	$800.00	$0.00
April 2, 2010	97750-FC x 12 units	$538.80	$0.00
TOTAL		$2,938.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
3. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. 28 Texas Administrative Code §134.204 sets out medical Fee Guidelines for workers' compensation specific services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 21, 2010
   - NDOC – 17 – PMT ADJUSTED AS REQUESTED INFO WAS NOT PROVIDED OR WAS INSUFF/INCOMPL. DOCUMENTATION RECEIVED DOES NOT HAVE DETAILED INFORMATION TO DETERMINE APPROPRIATENESS OF BILLED PROCEDURE.
   - TX27 – W1 – WORKERS COMPENSATION STATE F/S ADJU. FCES ARE ALLOWED A MAXIMUM OF THREE TIMES PER INJURED WORKER.

   Explanation of benefits dated January 31, 2011
   - DENY – 151 – PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFO SUBMITTED DOES NOT SUPPORT THIS MANY SERVICES. REIMBURSEMENT IS DENIED BECAUSE THE MAXIMUM NUMBER OF VISITS OVER THE LIFE OF THE CLAIM WAS EXCEEDED.

   Explanation of benefits dated February 2, 2011
   - NDOC – 17 – PMT ADJUSTED AS REQUESTED INFO WAS NOT PROVIDED OR WAS INSUFF/INCOMPL. DOCUMENTATION RECEIVED DOES NOT HAVE DETAILED INFORMATION TO DETERMINE APPROPRIATENESS OF BILLED PROCEDURE.
   - P10G – W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. BASED ON ADDITIONAL INFORMATION RECEIVED, AN ADJUSTMENT IS BEING MADE TO THE ORIGINAL TOTAL INVOICE.

   Explanation of benefits dated March 23, 2011
   - P26A – W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. BASED ON ADDITIONAL INFORMATION RECEIVED AND APPROVAL FROM ADJUSTER, AN ADJUSTMENT IS BEING MADE TO THE TOTAL REIMBURSEMENT OF THE ORIGINAL INVOICE.

Issues

1. Have the services in dispute been reimbursed by the respondent?
2. Does a medical fee dispute still exist?
3. Is the requestor entitled additional to reimbursement?

Findings

1. Review of the documentation submitted finds that the requestor billed $800.00 for CPT code 97799-CP for date of service March 11, 2010, $800.00 for CPT code 97799-CP for date of service March 12, 2010, $800.00 for CPT code 97799-CP for date of service March 19, 2010 and $538.80 for CPT code 97750-FC for date of service April 2, 2010.
2. Review of the documentation submitted by the respondent finds an explanation of benefits dated February 2, 2011 showing reimbursement was made to the requestor in the amount of $800.00 regarding CPT code 97799-CP for date of service March 11, 2010 as billed, $800.00 regarding CPT code 97799-CP for date of service March 12, 2010 as billed and $800.00 regarding CPT code 97799-CP for date of service March 19, 2010 as billed. Review of the documentation submitted by the respondent finds an explanation of benefits dated March 23, 2011 showing reimbursement was made to the requestor in the amount of $538.80 regarding CPT code 97750-FC for date of service April 2, 2010 as billed. The Division concludes that a dispute no longer exists and no further action will be taken regarding this dispute.
3. Therefore, the no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $ 0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Debra Hausenfluck Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.